# Addis Ababa University
# College of Education and Behavioral Studies
# School of Psychology


**Resilience Level, Risk Behavior and Protective Factors of HIV Positive Adolescents at Mekdim Ethiopia National Association**


**Liyu Wogayehu**



**Feb, 2015**
**Addis Ababa**

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## Resilience Level, Risk Behavior and Protective Factors of HIV Positive Adolescents at Mekdim Ethiopia National Association


**Liyu Wogayehu**


**A Thesis Submitted**
**In Partial Fulfillment of the Requirements for the Degree of**
**Master of Arts in Developmental Psychology**


**Feb, 2014**
**Addis Ababa**

**Resilience Level, Risk Behavior and Protective Factors of HIV Positive Adolescents at Mekidim Ethiopia National Association in Arada Sub city, Addis Ababa.**

By

**Liyu Wogayehu**

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## Table of Contents

# List of Tables

Page

## Acronyms

| | |
|---|---|
| ART | Anti-Retroviral Therapy |
| AIDS | Acquired Immune Deficiency Syndrome |
| ALHIV | Adolescent Living with HIV |
| CD-RISC | Connor Davidson Resilience Scale |
| HIV | Human Immune Deficiency Virus |
| MTCT | Mother to Child Transmission |
| PTSD | Post Trauma Stress Disorder |
| TEFRL | Teachers of English as a Foreign Language |
| UNICEF | United Nation Child Fund |
| WHO | World Health Organization |

## Acknowledgements

First of all I would like to thank the almighty of God for giving unconditional love to me. I wish to express my deepest gratitude and appreciation to my advisor Ato Daniel Tefera for his critical, insightful and constructive comments in accomplishing this study.

I would like to note my sincere thanks to my friends who supported me in my entire journey at AAU and paper work. Many thanks to my families for their love and support. Finally, I would like to thank all Mekidim Ethiopia National Association employees.

Thank you all!!

# Abstract

*The aim of this study is to examine the resilience level, risk behavior and protective factors of HIV positive adolescents who are a member of the Mekdim Ethiopia National Association at Arada Sub city Woreda 6. Participants of this study were 100 HIV positive adolescents (52 males and 48 females) who are benefiting from Mekdim Ethiopia National Association at Arada sub city Woreda 6. Data collected through questionnaire, Connor Davidson Resilience Scale (CD-RISC), Risky Behavior Rating scale (PWC) and developed protective factor and biographical form. Data analyzed using both descriptive and inferential statistical methods. Descriptive statistics (percent, Mean and SD) and inferential statistics such as ANOVA and t- test were employed to uncover the associations among the variables considered. The results revealed that level of Resilience of HIV positive adolescents who are a member of Mekdim Ethiopia National Association is considered to be low. HIV positive adolescents who are a member of Mekdim Ethiopia National Association are at risk of participating in activities which are great impact on their health status. The major protective factors of HIV positive adolescents were spirituality, living with their parents or guardians and have good performance in their educational status. The result reviled that there is no statically significant difference among HIV positive male and female adolescents. Low resilient level adolescents use potentially high risky behaviors such as chewing chat, smoking in high proportion as a coping mechanism. Practical implications of the findings are present.*

# Chapter One

# 1. Introduction

## 1.1 Background

The construct of resilience has gained considerable attention over the last four decades since researchers observed that children and youth could cope and adapt in spite of adversity. Resilience involves a dynamic process involving an interaction between both risk and protective processes, internal and external to the individual that can modify the effects of an adverse life event. Charney, (2004) and Masten(2001).

According to Aidwin (1990), Cook (1998), Tsuaung (2000), Selignmon and Crikszentmihalyi (2000) some young people begin life with certain advantages. They would be either born with, or would develop through the interaction of genetic and environmental factors, internal strengths or qualities that enable them to cope better with life. According to these researchers' adolescents who were motivated to be observant and good at solving problems believe in their own ability to cope with difficulty. Such adolescent were also more likely to understand and attribute a deeper meaning to adverse events.

Rutter (1999) and Werner (1995) mentioned resilience is a protective factor that facilitates positive outcomes for children who are faced with adverse life events. These risks and protective factors are often interplay between genetic, personal and environmental factors (Rutter, 1999; Werner, 1995).Some of the internal factors that contribute to resilience include

flexibility, autonomy, sense of humor, internal locus of control, perceptiveness, creativity, self-motivation, good decision making skills etc. Other positive factors which lead to the development of resilience include good parenting, faith and religious affiliation, talent valued by society and self, a sense of meaning in life, good schools, good intellectual skills, community resources etc.

In the other side a risk factor is any factor associated with the increased likelihood of a behavior that usually has negative consequences (Spooner, Hall and Lynskey, 2001). When adolescents develop problems, the source of the problems can often be traced to risk factors, such as poverty, poor family relationships, infected or/and affected by chronic illness, abusive or neglectful parenting, and inadequate schools. However, there are also many adolescents who face terrible conditions yet manage to adapt and function well. Resilience is the term for this phenomenon, defined by many researchers as good outcomes in spite of serious threats to adaptations and development. Many research findings (Spooner, Hall and Lynskey, 2001) indicate that most children and youth, even those from highly stressed families or resource-deprived communities, do somehow manage to make decent lives for themselves.

Research has shown that there are many risk factors that increase the chances of adolescents developing health and behavior problems. Hawkins, Catalano and Miller, (1992)identified 17 risk factors that are associated with alcohol, tobacco, and other substance use among adolescents and categorized them as “contextual factors”, which are related to culture and the structure of society, and “individual and interpersonal factors”. The more risk factors are present, the greater the likelihood of young people engaging in alcohol, tobacco, violent behavior, school dropout, sexual behavior and substance use. Hawkins, Catalano and Miller, (1992) identified protective factors that can reduce this likelihood.

Resilience is a key factor in children's and adolescent ability to cope with and survive adversity (Grotberg, 2003). Promoting resilience is therefore critical as this may contribute to the prevention of negative outcomes for youths challenged by significant stressors such as those posed by the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) epidemic (Rolf & Johnson, 1999).

In addition, UNICEF (2006) and WHO & UNICEF (2007) further reported that the HIV and AIDS epidemic is one of the greatest tragedies confronting human kind. Reports on the numbers of children, families and communities living with HIV and those affected by HIV and AIDS across the globe are overwhelming in their proportions.

Based on those findings this research aimed at identifying the risk behaviors of adolescence living with HIV and the possible protective factors to become resilient.

## 1.2 Statement of the Problem

Adolescence is a developmental phase between childhood above 10 years and adulthood under 19 years characterized by physical, psychological, and social change at the individual level (WHO, 2010).The transition of adolescents with a special health need, such as HIV, has been described as a multifaceted, active process that attend to the medical, psychological, and educational or vocational needs of adolescent as they move from the child focused to the adult focused health care (Reiss & Gibson 2002). In Sub Saharan Africa where over 80% of all HIV/AIDS deaths occur and where over two thirds of new infections originate, HIV/AIDS is a disease of the poor and the disempowered, unlike developed countries it is also predominantly a heterosexual disease - affecting couples, parents, and family. As a result, children are one of the most severely affected and exposed population groups (UNICEF, 2007).Before 2005, adolescents those who are infected with HIV through mother to child

transmission were nonexistent while today adolescents who infected with HIV during their early childhood but still alive are appeared. The emergence of this group considered as a unique and unplanned for a population policy makers; programmers which in turn limits social and psychological support which this infected groups must issue (UNICEF, 2007).

Adolescent, whether it involves living with HIV or not, is a period where an individual undergoes major social, physical, and psychological changes. This period can be more difficult for adolescent living with HIV (ALHIV) that face additional challenges due to the loss of parents and other relatives (Andrews, Skinner, & Zuma, 2006; Cluver, Gardner, & Operario, 2007; Petersen et al., 2010), a delayed onset of puberty (Li et al., 2010), and may have difficulty coping with adherence, disclosure, stigma, and sexual relationships (Menon, 2007; Miles, Edwards, & Clapson 2004; Ross , 2010; While , 2004; WHO 2009). It is important that transition programs and policies recognize and adapt to these needs, while taking into consideration the developmental process of adolescence. To this end the following research questions are posed to be answered:

1 Is there a significant difference among HIV positive adolescent in Mekidim Ethiopia National Association in their resilient level?
2 What are the risk behaviors that HIV positive adolescents are involved in?
3 What are the protective factors employed by HIV positive adolescents of Mekidim Ethiopia National Association?
4 Is there statistically significant sex difference among HIV positive adolescents in their level of resilience?
5 Is there a difference in their level of resilience among HIV positive adolescents who use different protective factors?

## 1.3 General Objective

Assess the resilience level, risk behavior and protective factors of HIV positive adolescents who are a member of Mekdim Ethiopia National Association at AradaSubcityWoreda6, in Addis Ababa.

### Specific Objectives

- To determine the resilience level of HIV positive adolescent in the Mekdim Ethiopia National Association located in Arada subcityWoreda6, in Addis Ababa.
- To identify the risk behavior of HIV positive adolescents.
- To explore the protective factors employed by HIV positive adolescents of the Mekdim Ethiopia National Association.
- To explore whether male and female HIV positive adolescents differ in their level of resilience.
- To explore the difference in the level of resilience among HIV positive adolescents who use different protective factors.

## 1.4 Significance of the Study

The results of the study will be used by concerned bodies such as association which have HIV positive people who engaged in care and support activities, family, communities, schools, and government bodies who are dealing directly or indirectly with adolescents living with HIV. These social agents would be able to understand the existence of variation in the level of resilience among adolescents living with HIV despite multiple stressful situations in their lives. These bodies would take note of the major risk behavior and protective factors that HIV positive adolescents involved in so that which, familial, social and environmental factors that

boosts resilient personality. The findings will help them evaluate and restructure their policies and approach toward HIV positive adolescents. There is no literature on this topic which is relevant for our country so this study will be used as a base line for our country.

Furthermore, suggestions on the importance of promoting resilience would call for other researchers in the area extending resilience based studies in HIV positive adolescent in Ethiopia found at different developmental stages and living situations. Finally, this study would have a contribution to the ongoing resilience researchers conducted in another part of the world.

## 1.5 Delimitation

The research focused on adolescents living with HIV whose age ranges 10-19 and supported by Mekdim Ethiopia National Association in Addis Ababa it does not include adolescents living with HIV and supported by others associations so it may not be generalized for the country.

## 1.6 Operational Definitions of Terms

- Resilience: In this study is the capacity of adolescents to effectively cope with, adjust or recover from knowing their resilience level.
- Risk Behavior-un healthy activities in which HIV positive adolescents involved in.
- Protective factor-A protective factor is any factor that reduces the impact of a risk behavior, helps individuals not to engage in potentially harmful behavior, and/or promotes an alternative pathway.

# Chapter Two

## 2. Reviews of Related Literature

### 2.1 Overview

Resilience is defined in multiple ways and has developed over time as the concept has grown in popularity and received more attention in the literature. Simply stated, resilience is a positive adaptation in the face of significant threat. As such, resilience also refers to individual variations in abilities to cope positively in the face of adverse and threatening circumstances (Foster & Williamson, 2000; Grotberg, 1995; Rutter, 1990).

It is generally recognized that resilience is a process through which people, including children and adolescent, are able to continue or resume a long term positive trend in growth and adaptation, despite their exposure to adversity (Mc. Callin, 2005; Bouvier, 2005). The conceptualization of resilience as a process rather than a state or trait acknowledges that resilience is a dynamic, ongoing, active capacity, which children and adolescent development over the lifespan; and that it is dependent on interactions between individuals and the environment, and established and maintained through relationships.

### 2.2 Risk Behavior during Adolescents

Adolescence is a time of initiation of several risk–taking behaviors such as alcohol consumption, sexual intercourse and drug consumption. In his study, Seloilwe, (2001) reported that the first exposure to penetrative sex among adolescents occurs between 12 and 14 years. Another study conducted on HIV-positive youths and adolescents (Naar-King et al., 2006), indicates that the group continues to engage in risky behaviors that affect individual health status

and pose concern for public health. The genesis of the risky behaviors of positive adolescents can be attributed to depression and other pressures of living with the virus.

In addition, (Mc. Whiter, 2007) reported that adolescence is a time when risk behaviors begin to increase through experimentation with health risk behaviors such as substance used and reckless driving and exploratory risk behaviors such as asking someone on a date and standing up to peers. It is likely that some risk-taking is necessary in the course of social and academic development throughout childhood and adolescence.

Depressed HIV-infected adolescents may be more apathetic and less concerned that they may be exposing themselves to additional infectious agents or risking infecting a partner with HIV. On the other hand, depressed HIV infected adolescents may seek to engage in unprotected sex to alleviate their depression (Murphy et al., 2001).

However, longitudinal data in a study titled *Sexual Behavior Change among Human Immunodeficiency Virus-Infected Adolescents with Hemophilia* undertaken by Larry et. al, indicated that improvement and maintenance of safer sexual behavior among adolescents during an intervention is strongly associated with perceptions of peer support for safer sex and lesser degrees of emotional distress. The researchers add that programmers for HIV-infected adolescents may require developmentally appropriate social and psychological approaches to impact peer norms and emotional well-being.

Risk refers to endogenous (internal) or exogenous (external) variables that increase the chance of negative outcomes in development (Masten, 2001). Risk may be a combination of individual, familial, and socio-demographic factors which threaten healthy emotional, social, psychological and physical development and place the child '*at risk*' for future negative outcomes (Mangham, McGrath, Reid, & Stewart, 1996 & Mc Whiter, 2007).

Liddell (2002) suggests that the risks are "multidimensional in origin, interactive in process, and cumulative in their effects". Exposure to risk can open up the likelihood of further exposure to risks through spirals by which outcomes at one age become adverse antecedents at another stage. The impact of exposure to risk is cumulative. The greater the intensity of risk factors, the longer the exposure to risks, and the greater the number of risk factors to which a child is exposed, the greater will be an individual's likelihood of showing adverse outcomes (Mc. Whiter et al., 2007).

Children and adolescent are at higher risk of multiple adversities which extend over time. The death of a parent or other caregiver, being HIV positive, for example, is not a single event, but an often lengthy process of multiple stressors and changes occurring before, during, and after the death itself (Masten, 2001).

Resilience allows the adolescent to adapt and respond to the causes of risks more effectively. Many factors such as a lack of social support and concurrent stressors have been linked to poor adjustment and when these factors accumulate they tax the psychological and emotional capacity of children and their families and hence result in an increased risk of dysfunction and negative consequences.

Steps taken to protect children from risk depend very much on how risk is, whether the risk is attributed to human agency or personality type, a world of avoidable or unavoidable dangers, or supernatural forces or fate. In addition, it also depends on whether child development is perceived as a process of natural maturation or whether it is seen as a process that occurs in direct interaction with the environment, principally facilitated by caregivers (Liddell, 2002).

Newman (2005) summarizes the current state of knowledge highlighting that risk factors tend to be cumulative, that acute stressors are usually less harmful than chronic ones, and

if the chain of risks is broken, that child and adolescent have opportunities to resume their normal developmental course and most children and adolescent can recover.

## 2.3 Resilience

Initially the idea of resilience focused on avoiding or minimizing risk factors and exploring resilient personality traits. As stated earlier resilience is now recognized as a dynamic process involving the complex interplay of risk and protective factors. The individual showing resilience is not showing a static resilient trait. Rather, they demonstrate a positive outcome within a particular set of circumstances at a given time.

Bernard (1991, p. 245) identified three characteristics that were predictive of positive outcomes for children in risk laden environments.

These were:

(i) A meaningful relationship with at least one caring and supportive adult

(ii) The presence of high expectations for the child's future

(iii) The chance for meaningful participations,

Other studies, such as Werner (1990), have demonstrated that favorite teachers and caring friends contribute substantially to the development of resilience amongst disadvantaged groups. Three characteristics of resilience in Werner's work include having a sociable personality, a supportive adult and opportunities for achievement.

Grotberg (1995) proposes that resilience should also be thought about as existing beyond the individual level, in that groups and communities may also be collectively resilient. Grotberg extends the definition of resilience to "a universal capacity which allows a person, group or community to prevent, minimize or overcome the demanding effects of adversity". The

evidence is growing that connection to caring adults and to places such as schools which offer support and structure as being part of the development of resilience.

In general, most experts agree that resilience develops and changes over time, is enhanced by protective factors within the individual and the environment (particularly supportive relationships) and contributes to the maintenance or enhancement of health and wellbeing. Resilient children often exhibit flexibility, good communication skills and an ability to be reflective; they tend to have a sense of independence and mastery and a sense of a purpose and a future. A developmental perspective on resilience argues that some children and adolescent will vary in the degree of resilience they demonstrate at different points in their lives (Killian, 2005).

## 2.3 Resilience and HIV/AIDS

Sub-Saharan Africa has the highest HIV burden in the world, with 67 percent of the estimated 34 million people living with HIV. Globally, children under 15 years are particularly hard hit: 3.4 million are living with HIV, 90 percent of them live in sub-Saharan Africa (WHO 2011). Approximately one-third of infants born to mothers living with HIV are not on antiretroviral therapy (ART), either for their own clinical care or for the prevention of mother-to-child transmission, and will be infected during pregnancy, birth, or breastfeeding (WHO 2011). Until recently, it was assumed few children infected during this period would live beyond their fifth birthday. Recent data have emerged to challenge this assumption because children infected from mother (via vertical routes) are now entering adolescence in sub-Saharan Africa. Recent projections suggest that 36 percent are slow progresses and have a median survival age of 16 even without access to treatment (Ferran, 2009).

Moreover, many children who acquire HIV during the prenatal period and are subsequently on ART are now expected to live a long healthy life. However, they live with a host of clinical and psychosocial care needs that most community support and health systems in sub-Saharan Africa are not equipped to address (Ferrand et al., 2010; Li et al., 2010; Petersen et al., 2010; Valenzuela et al., 2009). With recent evidence showing that ART can prevent sexual HIV transmission among sero- discordant couples Cohen et al., (2011), decisions about when to start treatment, adherence, and retention become even more critical to address among adolescents living with HIV. Transition can be both a mental and physical reality for all adolescents living with HIV, and services should promote self-care that includes adherence to ART and the adoption of appropriate individualized prevention strategies to help reduce further HIV transmission (Lancet, 2011)

## 2.4 Adolescent Living with HIV and AIDS

Adolescents living with HIV and AIDS have a lower life expectancy, require access to pediatric treatment which is seldom available and may be vulnerable to stigma and discrimination and the pain and distress associated with a chronic illness. Despite HIV and AIDS introducing a multitude of risk factors for children research indicates that children and adolescent develop resilience through ongoing supportive and caring relationships, continued social network associations and participation in familiar institutions (Kruger, 2006; Garmezy, 1993; Condly, 2006).

Killian (2004) proposes that it is clear that certain families, schools, communities and cultures have protective characteristics that promote resilience. Resilient families who live in poor and disrupted communities, yet cope successfully through disadvantage, serve as important positive role models for their adolescents. As highlighted by the review of the evidence above,

resilience is a complex concept. Resilience is dependent on the length, nature, number and intensity of exposure to risk factors, the internal qualities of a child, and the 'external' experiences, relationships and context within which a child is embedded. Of critical importance is the recognition that the interplay of these factors is also situated within family and societal contexts (Lazarus, 2004).

## 2.5 Risky Factors Related with HIV/AIDS during Adolescents

Risk may be a combination of individual, familial, and socio-demographic factors which threaten healthy emotional, social, psychological and physical development and place the child '*at risk*' for future negative outcomes (Mc. Whiter, 2007).Risk and protective factors are often the flip side of the same coin. Risks are at the negative end of a continuum of factors at the personal, family, school and community level. Risk factors are seldom one-dimensional or separate events; they tend to cluster together as part of a complex set of person-environmental interactions (Haggerty & Sherrod, 1994). In recognition of this, the focus in resilience research shifted to understanding the interrelatedness and clustering of risk factors. For example, poverty is associated with significant clustering, and results in disproportionate exposure to multiple risk factors such as inadequate health care and housing, family stress and the like (Garmezy & Masten, 1994). Many factors such as a lack of social support and concurrent stressors have been linked to poor adjustment and when these factors accumulate they tax the psychological and emotional capacity of children and their families and hence result in an increased risk of dysfunction and negative consequences.

Adolescence is a time of initiation of several risk–taking behaviors such as alcohol consumption, sexual intercourse and drug consumption. In a study (Seloilwe, 2001) it was noted that first exposure to penetrative sex among adolescents occurs between 12 and 14 years.

Another study conducted on HIV-positive youths and adolescents (Naar-King, 2006), indicates that the group continues to engage in risky behaviors' that affect individual health status and pose concern for public health. The genesis of the risky behaviors' of positive adolescents can be attributed to depression and other pressures of living with the virus. Depressed HIV-infected adolescents may be more apathetic and less concerned that they may be exposing themselves to additional infectious agents or risking infecting a partner with HIV. On the other hand, depressed HIV infected adolescents may seek to engage in unprotected sex to alleviate their depression (Murphy, 2001).

Of equal concern is the frequent use of marijuana among other drugs by some HIV positive adolescents ostensibly to deal with health anxiety evolving from the positive status, pressure at school and unemployment among other social challenges. "From some observations and confessions during counseling sessions, some of the adolescents use marijuana to help deal with Feelings of anxiety related to their health (Liddell, 2002).

The risk for acquiring human immunodeficiency virus (HIV) infection during adolescence and early adulthood starts with initiation of sexual behavior or injection drug use, and initiation of contributing behaviors such as use of alcohol and other drugs (Murphy, 2001).

## 2.7 Protective Factor

Moreover, spirituality considered a key factor in fostering resilience in the adolescents as it encompasses existing and shared inner strengths, as well as interpersonal and problem-solving skills, such as hope and morality. Morality, social values and resistance skills denote beliefs concerning what is right and wrong. A belief in one's own competence and skills, that things can change for the better, that there is hope for the future, and that one can control the

direction of one's life, represents optimism, positive identity and faith has been shown (Liddell, 2002).

Religion may be understood as the external expression of a child's faith or inner system of beliefs, which includes ethical codes and various forms of worship (Greene & Conrad, 2002). These culminate in the children's belief systems, and may inform and provide guidance regarding other aspects of their lives. As children build on and develop these inner developmental and asset-related traits, they may construct a strong internal locus of control which seems fundamental to transcending risk in their lives. Hence, these children's beliefs and convictions can be powerful healing tools.

Grotberg (1995) posted that, the clearest implication of this investigation is that it is important to invest in efforts to promote healthy relationships and social and emotional development in HIV/AIDS-affected children. Failure to do so may be costly to both children and to society. With adequate support, children can be extremely resilient to stressors. Teachers and adult caregivers play a key role in rendering this support. They may not only fill basic needs, but also further needs such as expanding the worldview of children, provoking a sense of understanding and direction, and creating environments in which children can feel valued as significant contributors. They may create opportunities to develop (individual) strengths, acknowledge the existence of children and their rights, some of which include the right to identity, participation in decisions affecting their lives, education, and appropriate alternative care Grotberg (1995).

# Chapter Three

## 3. Methods

### 3.1 Research Designs

This research descriptive in nature and utilizes quantitative approach in the collection and analysis of data. The use of this design is believed to help us determine whether the variables under study have some kind of association or not.

### 3.2 Study Site

The study was conducted in Addis Ababa, Ethiopia at Mekdim Ethiopia National Association. The Head Office is located at Arada sub city Woreda Six. The rationale behind the researcher has chosen this area as study site is that since the researcher is working with adolescents living with HIV positive the researcher is wonder to the resilience capacity of this groups which might help researcher to design appropriate measure in order to improve the resilience capacity of this groups.

### 3.3 Target Population

All adolescents whose age is 10-19, who are living with HIV and members of the Mekdim Ethiopia National Association were the target of this study. Hence, the study participants are those adolescents selected from this age group following probability sampling techniques.

## 3 .4 Participants of the Study

Study involved HIV positive adolescents who are a member of Mekdim Ethiopia National Association and who benefited from care and support services in the association .The data was collected during their schedule for taking their care and support.

## 3.5 Sampling Procedure

One hundred adolescents (52 males and 48 females) hence for the intention of the study all adolescents benefited from this organization were included in the present study.

## 3.6 Data Collection Tools

Self-report instruments were used to measure variables of interest. The instruments have three parts. Part one comprised of structured items, which seek for the participants' sex, age, grade level, school type and family background.

### 3.6.1 Connor Davidson Resilience Scale (CD-RISC)

The other data collection tool used in the study was Connor and Davidson Resilience Scale (CD-RISC) which was published in 2003 by Connor and David. This scale was used to identify the resilience level of adolescents and their protective factors. The CD-RISC scale is comprised of 25 items that were deemed to be components of resilience. A higher score suggested an individual was more resilient. Each item is rated on a 5-point range of responses from not true at all (0) to true nearly all time (4). The total score ranges from 0–100. A preliminary study of psychometric properties of the scale in a general population and patient samples showed adequate internal consistency, test-retest reliability, and convergent and divergent validity. To validate the scale, Connor and Davidson distributed it to five populations: a non-help-seeking general population, primary care outpatients, and psychiatric outpatients in

private practice, participants in a study of generalized anxiety disorder, and participants in two PTSD clinical trials

Regarding scoring, from the total score 100, adolescents those who score below 45 considered as low resilient group, those who achieve between 45- 55 were considered as medium resilient group and those who score above 56 were considered as high resilient groups. This scoring method was accepted from previous research study done on the same area (Bisrat, 2005).

### 3.6.2 Risk Behavior Rating Scale

In order to assess risky behaviors of HIV positive adolescents, the Risk Behavior Rating scale developed by Theodore Christ in (2009) was used. Basically in our context this instrument was used by (Besirat, 2005) for the same purpose. The scale is comprised of 13 items that are deemed to be components of risky behavior. A higher score on each item suggested an individual was more exposed to risky behaviors. Each item is rated on a (5)-point ranging scale of responses from never at all (0) to often (4).

### 3.6.3 Protective Factor

In order to examine the protective factors of HIV positive adolescents, adapted protective factor scale comprised of items for instance were used. The scale was adopted from previous research conducted on HIV positive adolescents. In the Ethiopian context, the instrument was used by (Besirat, 2005).The scale composed of 7 items. The items in this questionnaire include major domains of Social Resources; such as whom do you want to talk to or be with when you are feeling ‘down’? Who is the first person you would tell if you were worried about something?

## 3.7 Pilot Study

In order to check the feasibility of the study and the adequacy of the questionnaire, a pilot study was conducted in another HIV positive association adolescent who HIV positive.

Before distributing the scales for participants the instruments of data collection were translated from English to Amharic with the help of an MA student in the Department of Teaching English as a Foreign Language (TEFL). Backward translation of these instruments was done by another MA student in the same department. Some differences that appeared in the forward and backward translations were corrected by the two translators jointly.

Finally, the Amharic version of the instruments was pilot tested on a randomly selected HIV Positive association with the sample of forty HIV positive adolescents (20 males and 20 females). The responses of the respondents were scored and the reliability of the scales was computed using the SPSS software package, version 20.

After omitting two items because of their ambiguity, the overall internal reliability (Cronbach alpha) of the risking behavior self-report inventory was 0.76. Following this, 11 items were used in the final study. Regarding Connor Davidson Resilience Scale" (CD-RISC) the overall internal reliability of the scale was 0.85. All items (25) were used in the final study. Pertaining to protective factor scale of HIV positive adolescents, the overall internal reliability of the scale was 0.81. Hence all items 7 were used in the final study.

## 3.8 Data Collection Procedure

The CD-RISC and questionnaire were administered to the respondents through 4well experienced Nurse Counselors who attended a one day orientation about the purpose of this data collection and how to collect the data. In the first week of the data collection period, the

researcher made formal contact with the organization's executive director through a letter from Addis Ababa University, school of psychology. He was directed the letter to program manager to facilitate all things and the researcher discussed the objectives of the study and the tools would be used with the program manager and he recommended to use the counselors to call the adolescents in three phases based on their age and prepared discussion forum for the adolescents to inform about the objectives. Finally the manager advised me to prepare in ART adherence topic because the adolescents are not taking their ART drug appropriately.

## 3.9 Ethical Consideration

During administering the tool the researcher designed consent form for the participants. The participant whose age is above 15 signed on the consent form by themselves and participants whose ages are between 10 and 14 were asked to get the consent form signed by their parents/ guardians. The consent form described that the responses they provide could help to understand the health of HIV-positive youth. It also informed participants about their freedom not to answer any item they wished not to answer; they were also assured of the confidentiality of their responses. The consent form and questionnaire explicitly requested that no names or other identifying information be provided. Then, the Participants completed the paper-and-pencil inventory in a privately. After completing the inventory, they placed it on a table, mixed it with others, were thanked and let them go by providing the transport allowance.

### 3.10 Methods of Data Analysis

The quantitative data was checked for completeness and cleaned manually. The cleaned data was entered in Microsoft Office Excel 2010 version and export to SPSS (Statistical Package for Social Sciences) version 20. The descriptive findings are presented with tables. The summary of the finding will be used to explore new ideas and opinions of the participants. Data was

collected on daily bases and the principal investigator communicates with data collectors frequently. To investigate the resilience status of HIV positive adolescent's descriptive statistical method (mean) was employed. In order to identify risky behaviors of HIV positive adolescents involved in and protective factor these groups used descriptive statistical methods (mean, SD and percent) were used. In addition, to examine age and sex difference among HIV positive adolescents in their resilient status ONE way ANOVA was employed. Alpha =0 .05 was used for testing statistical significance in all tests.

# Chapter Four

## 4. Results

In this section description of findings are being presented. The analysis involves three parts. The first part involves description of the characteristics and background of participants in the study. The second part results that indicate the level of resilience of HIV positive adolescents are presented and the third part presents risky behaviors that HIV positive adolescents involved in and coping mechanism employed by these adolescents followed by protective factors these adolescents used are presented consequently.

## 4.1Demographic Characteristics of Participants

This section presents demographic characteristics of participants.

**Table 1: Background of Participants**

| **Categories** | | **Frequency** | **Percent** |
|---|---|---|---|
| Sex | Male | 52 | 52 |
| | Female | 48 | 48 |
| | Total | 100 | 100 |
| Age | Early Adolescent | 36 | 36 |
| | Mid Adolescent | 46 | 46 |
| | Late Adolescent | 18 | 18 |
| **Total** | | **100** | **100** |
| Educational status | 0 - 8 | 56 | 56 |
| | Grade 9 and 10 | 33 | 33 |
| | Above 11 | 11 | 11 |
| | **Total** | **100** | **100** |
| With whom you are | Parents | 69 | 69 |

| | | | |
|---|---|---|---|
| living | Foster and shelter care | 18 | 18 |
| | Relatives and others | 13 | 13 |
| **Total** | | **100** | **100** |
| Current employment status of respondents | Working | 9 | 9 |
| | Not working | 91 | 91 |
| | **Total** | **100** | **100** |

As shown in the above table, 36% of the participants were found at early adolescent stage. The second age group that has many participants is middle adolescent (46%). Generally, many participants were late adolescent stage.

Regarding the gender of the respondents, the proportion of males and females were 52 and 48 percent. This implies that there is no huge difference between the frequency of males and females.

Pertaining to educational status of respondents 56 % of them were below grade Eight, 33% of them were between grade Nine and Ten and the rest 11% were above preparatory.

69% of adolescents that participated in this study are living with their parents, 18% are living either in foster or shelter care and the rest 13% were living with their relatives .Regarding the working situation of participants, only 9% of them are involved in income generating activity and the rest 91% are not involved in any form of income generating activity.

**Table 2: HIV Positive Adolescents Resilience Level**

| Statistics | Low groups | Medium groups | High groups |
|---|---|---|---|
| N | 44 | 17 | 39 |
| Mean | 38.44 | 49.46 | 77.67 |
| SD | 4.34 | 2.93 | 8.47 |

***NB: Low resilient score > 45, Medium resilient score 45 – 55 and above 56 considered as high resilient group***

As indicated in the above Table, from the total participants of the study (44%) them were categorized as low resilient level group with mean (38.44) and SD of (4.34), 17% of them as medium resilience level groups with mean (49.46) and SD of (3.27) and, 39 (39%) of them were categorized as high resilient level groups with mean (77.67) and standard deviation (8.47). Generally from the above table we can conclude that many adolescents are low in their resilient level.

**Table 3: Risky Behaviors HIV Positive Adolescents Involved in**

| Categories | Number | Mean score on risky behavior scale |
|---|---|---|
| **High risky behavior adolescents** | **88** | **49.37** |
| **Low risky behavior adolescents** | **12** | **24.54** |

As can be illustrated in the above table many HIV positive adolescents are in high risky behavior with the mean score of (49.37) on risky behavior whereas among participants of the study only 12 HIV positive adolescents are in low risky behavior with the mean score of( 24.54) on risky

behavior scale. Generally from the above table we can infer that participants of the study are at risk of participating in activities which are great impact on their health status.

**Table 4: Protective Factors Used by HIV Positive Adolescents to overcome their Emotional stressful situation**

| Items | Frequency | Percent % |
|---|---|---|
| Pray | 45 | 45 |
| Talk to somebody | 35 | 35 |
| Drink alcohol | 4 | 4 |
| Chew chat | 4 | 4 |
| With drawl from activity | 1 | 1 |
| Thought avoidance | 4 | 4 |
| Yell others | 3 | 3 |
| Smoking cigarette | 3 | 3 |
| Others | 1 | 1 |

As depicted in the above table, among coping mechanism used by HIV positive adolescents, surprisingly 45% of them were resorted to praying to overcome their emotional disturbances followed by talk to somebody about their problem 35%. Drinking alcohol, chewing chat and thought avoidance contribute 4% each in overcoming their emotional disturbances. With drawl from activity contribute only 1%. Generally from the above table we can infer that among coping mechanism used by adolescents of with HIV positive, praying and talk to others contribute in collaborate 80%.

**Table 5: Educational status of HIV Positive Adolescents' and their Coping Mechanism**

| Preparatory and above | Frequency | Percent |
|---|---|---|
| - Praying | 5 | 35.72 |
| - Talk to somebody | 3 | 21.43 |
| - Drinking alcohol | 1 | 7.143 |
| - Chewing chat | 1 | 7.143 |
| - Thought avoidance | 1 | 7.143 |
| - Smoking | 2 | 14.18 |
| - marijuana | 1 | 7.143 |
| Total | 14 | 100% |
| grade nine and ten | Frequency | Percent |
| - Praying | 10 | 33.33 |
| - Talk to some body | 6 | 20 |
| - Avoid talking | 3 | 10 |
| - Chewing chat | 4 | 13.33 |
| - Yell others | 3 | 10 |
| - Smoking | 2 | 6.667 |
| - Others | 2 | 6.667 |
| Total | 30 | 100 % |
| Grade four to eight | Frequency | Percent |
| - Praying | 17 | 30.57 |
| - Talking to some body | 9 | 16.07 |
| - With drawl from activity | 2 | 3.57 |
| - Yell others | 3 | 5.38 |
| - Thought avoidance | 3 | 5.38 |
| - smoking | 7 | 12.5 |
| - Others | 7 | 12.5 |
| - Chewing chat | 5 | 8.92 |
| - Marijuana | 3 | 5.38 |
| Total | 56 | 100% |

As can be illustrated in the above table, coping mechanism used by adolescents of different educational status were not observed different. For instance, in terms of in praying, adolescents of preparatory and above score 35.72% followed by adolescents of grade nine and above 33.33% and grade eight and below 30.57 %. Regarding talking to others, adolescents of preparatory and above score 21.43% followed by adolescents of grade and above 20%

respectively. This illustrates the adolescents coping mechanism does not vary on account of their educational status

**Table 6: Living arrangement of HIV Positive Adolescents' and their Coping Mechanism**

| **With parents** | **Frequency** | **Percent** |
|---|---|---|
| - Praying | 33 | 47.82 |
| - Talk to somebody | 21 | 30.43 |
| - Drinking alcohol | 6 | 8.69 |
| - Chewing chat | 5 | 7.246 |
| - Smoking | 2 | 2.9 |
| **Total** | **69** | **100%** |
| Foster care and shelter | Frequency | Percent |
| - Praying | 8 | 44.44 |
| - Talk to some body | 4 | 22.22 |
| - Avoid talking | 3 | 16.67 |
| - Chewing chat | 1 | 5.56 |
| - Yell others | 1 | 5.56 |
| - Others | 1 | 5.56 |
| **Total** | **18** | **100 %** |
| With their relatives others | Frequency | Percent |
| - Praying | 2 | 15.38 |
| - Talking to some body | 2 | 15.38 |
| - With drawl from activity | 1 | 7.69 |
| - smoking | 3 | 23.07 |
| - Others | 1 | 7.69 |
| - Chewing chat | 2 | 15.38 |
| - Marijuana | 2 | 15.38 |
| **Total** | **13** | **100%** |

As can be depicted in the above table, adolescents those who are a living with their biological parents were more used praying 47.82% followed by talking to somebody about their problems 30.43%. similarly adolescents those who are living in the foster care and shelter more prone to pray 44.44% followed by talking to others about their problems 22.22%. However surprisingly adolescents those who are living their relatives and others were more prone to using chewing chat 15.38% and use of marijuana 15.38% equal proportion with praying 15.38% and talking to some body 15.38%.

From this we can infer that compare to adolescents those who are living with their biological parents and within shelter and foster care, adolescents those who are living with their relatives and others were more prone to use un healthy activities such as chewing chat, use of marijuana, smoking and the like as a means of coping to overcome their emotional problems.

**Table 7: Summary of One way ANOVA Result on the Difference between Male and Female Adolescents Living with HIV Positive in their level of Resilience status**

| | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| **Between Groups** | 27554.760 | 98 | 281.171 | 1.162 | .644 |
| **Within Groups** | 242.000 | 1 | 242.000 | | |

As depicted in the table above, no statistically significant difference was observed between male and female HIV positive adolescents in their level of resilience (F= .644, P > .05). This implies that adolescents' resilient level does not vary on account of their sex differences.

**Table 8: Adolescents Resilient Level and their Protective Factor**

| | Frequency | Percent |
|---|---|---|
| High Resilient group | | |
| - Praying | 21 | 53.85 |
| - Talk to somebody | 16 | 41.02 |
| - Drinking alcohol | 2 | 5.12 |
| **Total** | **39** | **100%** |
| Middle Resilient group | Frequency | Percent |
| - Praying | 6 | 35.29 |
| - Talk to some body | 5 | 29.41 |
| - Avoid talking | 1 | 5.88 |
| - Chewing chat | 2 | 11.76 |
| - Smoking | 2 | 11.76 |
| - Others | 1 | 5.88 |
| **Total** | **17** | **100 %** |
| Low Resilient group | Frequency | Percent |
| - Praying | 14 | 31.81 |
| - Talking to some body | 11 | 25 |
| - With drawl from activity | 1 | 2.27 |
| - Yell others | 2 | 4.54 |
| - Thought avoidance | 2 | 4.54 |
| - Chewing chat | 7 | 19.9 |
| - smoking | 6 | 13.63 |
| - Others | 4 | 9.09 |
| **Total** | **44** | **100%** |

As can be illustrated in the above table , adolescents of high resilient level are more involved in praying 53.85% followed by talking to others 41.02% and drinking alcohol is less used by adolescents as coping mechanism and only 5.12% of them use alcohol as coping mechanism for high level resilient adolescents.

Regarding adolescents of mid-level resilient, like adolescents of high level resilient, mid-level resilient adolescents also use praying 35.29 % and talking to others 29.41% followed by chewing chat 11.76% and smoking 11.76% as a coping mechanism. Avoid talking with others and other ways of coping are contribute 5.88 each.

Pertaining to adolescents of low resilient level, similar with high and midlevel resilient adolescents, adolescents of low level resilient use praying 31.81 % and talking to others 25%. But what makes this group different from high and mid-level resilient adolescents is that these low level resilient adolescents use chewing chat 19.9% and smoking 13.63% in high proportion as a coping mechanism. Other way of coping, thought avoidance and yell others in collaborate contribute only 18.2%.

**Table 9: Summary of One Way ANOVA of HIV Positive Adolescents Living Arrangement and their Resilient Status**

| Source of variance | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | 697.400 | 2 | 348.700 | 4.248 | .012 |
| Within Groups | 27099.360 | 97 | 279.375 | | |
| Total | 27796.760 | 99 | | | |

As can be depicted in the above table, statistically significant difference among adolescents of different living arrangement in their resilient status was observed ($f = 4.248$, $p > .05$)

To identify which groups are better in their resilient status Scheffe's post hoc comparison results as follows.

**Table 10: Scheffe's Pair Wise Comparison Of HIV Positive Adolescents' Living Arrangement and their Resilient Status**

| (I) With whom you live | (J) With whom you live | Mean Difference (I-J) | Std. Error | Sig. |
|---|---|---|---|---|
| Parents | foster and shelter | 6.138* | 4.417 | .384 |
| | relatives and others | 9.612* | 5.222 | .883 |
| Foster and Shelter | Parents | -6.138 | 4.417 | .384 |
| | relatives and others | 3.474 | 6.229 | .377 |
| Relatives and others | Parents | -9.612 | 5.222 | .883 |
| | foster and shelter | -3.474 | 6.229 | .377 |

As post hoc comparison result suggests, adolescents those who are living with their parents are better in their resilient status than adolescents those who are living with their relatives and others.

**Table 11: Summary of One Way ANOVA of HIV Positive Adolescents' Educational Status and Their Resilient Status**

| Source of variance | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | 235.290 | 2 | 117.645 | .414 | .662 |
| Within Groups | 27561.470 | 97 | 284.139 | | |
| **Total** | **27796.760** | **99** | | | |

As seen in the above table, there is no statistically significant difference among adolescents of different educational status in their level of resiliencies ($F = .414$, $p = .662$).

# Chapter Five

## 5. Discussion

In this chapter, the results reported in chapter four are interpreted and discussed in line with the main research questions raised. In addition the findings are related, compared and contrasted with the previous research results which were reviewed and summarized in review of related literature section.

### 5.1 Resilience Status of HIV Positive Adolescents

As indicated in the result section of the present study out of the total participants 44% of them were categorized as low resilient group followed by 39 % of high and 17 % of them as medium resilient groups. This finding tells us that resilient capacity of adolescents living with HIV is low. Similar to this finding, Killian (2004) suggested that certain families, schools, communities and cultures have protective characteristics that promote resilience capacity of adolescents with HIV. Hence from this finding we can understand that participants of the present study have less access to get protective characteristics which would enhance these adolescents resilient capacity.

The possible explanations for the low resilient capacity of adolescents with HIV positive might be since even today in our context the issue of stigma and discrimination on individuals with HIV positive is still significant impact which in one way or another negatively influence resilient capacity of these groups.

### 5.2 Risky Behaviors HIV Positive Adolescents Involved In

As depicted in the result section of the present study, participants of the study are at risk of participating in activities which are great impact on their health situation. Among different risky behaviors HIV positive adolescents participated in, alcoholic behavior, use of

smokeless and tobacco, sexual intercourse without any form of birth control and condom and use of chat were the leading.

Consistent with this findings after conducting study conducted on HIV-positive youths and adolescents (Naar-King 2006), indicates that the group continues to engage in risky behaviors' that affect individual health status and pose concern for public health. In addition He also stated that the genesis of the risky behaviors' of positive adolescents can be attributed to depression and other pressures of living with the virus.

HIV-infected adolescents may be more apathetic and less concerned that they may be exposing themselves to additional infectious agents or risking infecting a partner with HIV. Furthermore, (Murphy 2001) indicates that, many HIV positive adolescents frequently use marijuana among other drugs ostensibly to deal with health anxiety evolving from the positive status, pressure at school and unemployment among other social challenges.

Generally HIV positive adolescents participated in this study is at a great risk of living long life. In line with this idea (Murphy 2001) suggested that risk for acquiring (HIV) infection during adolescence and early adulthood starts with initiation of sexual behavior or injection drug use, and initiation of contributing behaviors such as use of alcohol and other drugs.

**5.3 Protective Factors** for HIV **Positive**

In line with this finding, (Greene & Conrad, 2002) concluded that spirituality is considered a key factor in fostering resilience in the adolescents as it encompasses existing and shared inner strengths, as well as interpersonal and problem-solving skills, such as hope and morality. Morality, social values and resistance skills denote beliefs concerning what is right and wrong. A belief in one's own competence and skills, that things can change for the better, that there is hope for the future, and that one can control the direction of one's life, represents

optimism, positive identity and faith. Religion may be understood as the external expression of an adolescent's faith or inner system of beliefs, which includes ethical codes and various forms of worship.

Similar to this finding (Murphy 2001), reported that the ability to access social support is significant in predicting resilience. Resilient children trust and enjoy secure attachments to others confident that people will be there for them. They thus seek and find emotional support and are confident of their right to such support. They relate to others in a positive manner and have the ability to see humor in difficult situations. They also discuss difficulties with people whom they trust and respect.

**5.4 Educational status of as a Protective Factor for HIV Positive Adolescents'**

As indicated in the result section of the present study, adolescents, those who are living with their biological parents were more prone to praying followed by talking to somebody about their problems. Similarly adolescents, those who are living in the foster care and shelter more prone to praying followed by talking to others about their problems. However, surprisingly adolescents, those who are living with their relatives and others were more prone to chewing chat.

From this we can infer that compared to adolescents, those who are living with their biological parents and within shelters and foster care, adolescents, those who are living with their relatives and others were more prone to use unhealthy activities such as chewing chat, smoking and the like activities as a means of coping to overcome their emotional problems.

### 5.5 Living arrangement as a Protective Factor for of HIV Positive Adolescents'

As indicated in the result section of the present study, adolescents those who are living with their biological parents were more prone to pray followed by talking to somebody about their problems. Similarly adolescents those who are living in the foster care and shelter more prone to pray followed by talking to others about their problems. However surprisingly adolescents those who are living with their relatives and others were more prone to chewing chat and use of Chat.

From this we can infer that compare to adolescents those who are living with their biological parents and within shelter and foster care, adolescents those who are living with their relatives and others were more prone to use un healthy activities such as chewing chat, use of marijuana, smoking and the like activities as a means of coping to overcome their emotional problems

### 5.7 HIV Positive Adolescents' Educational Status and their Resilient Level

As depicted in the result section of the present study, one way ANOVA result indicates that a there is no statistically significant difference among adolescents of different educational status and their resilient level. This tells us that adolescents' resilient status does not vary on account of their educational status. However, as can be depicted in the result section of the present study, adolescents those who perceive their academic performance as excellent score high on resilient status scale than their counter parts of adolescents those who perceived their academic performance as average, above average and below average.

## 5.8 The Difference between Male and Female Adolescents Living with HIV Positive in their Resilience Level

As indicated in the result section of the present study there is no statistically significant difference between male and female HIV positive adolescents in their resilience level. This implies that adolescents' resilient capacity does not vary on account their sex differences. In opposite of the present findings, Naar-King (2006) reported that in developing countries girls are more likely to have to sacrifice their education, take on household responsibilities and chores and be accorded a lower status than boys all of which seem to make them less resilient than their male counterparts.

The possible explanation for the dissimilarity of the present findings with the previous findings is that since adolescents of the present study have no especial training on how to cope up with several challenges that may appear with HIV disease both groups does not vary on their resilient capacity.

## 5.9 Resilient Levels of HIV Positive Adolescents' and Their Protective Factor

As indicated in the result section of the present study, adolescents of high resilient level are more involved in praying followed by talking to others and drinking alcohol is less used by adolescents as coping mechanism and only limited percent of them use alcohol as a coping mechanism for high level resilient adolescents. Consistent with this finding(Greene & Conrad, 2002) reported that spirituality is considered a key factor in fostering resilience in the adolescents as it encompasses existing and shared inner strengths, as well as interpersonal and problem-solving skills, such as hope and morality. This informs us that adolescents of high resilient level are more spiritual.

Talking to others or social resource also considered as the second most used coping mechanism by high level resilient adolescents. Consistent with this finding,(Murphy 2001) reported that adolescents who discuss their difficulties with people whom they trust and respect help adolescents to develop relationships and a network of supportive others which they can draw on when difficulties arise. Such relationships serve as a buffer during adversity and create opportunities for positive interaction, messages and experiences. Generally adolescents of high resilient level use praying.

Regarding adolescents of mid-level resilience, like adolescents of high level resilient, mid-level resilient adolescents also use praying and talking to others. Pertaining to adolescents of low resilient level, similar with high and mid-level resilient adolescents, adolescents of low level resilient use praying and talking to others. But what makes this group different from high and mid-level resilient adolescents is that these low level resilient adolescents use chewing chat and smoking in high proportion as a coping mechanism. Other way of coping, thought avoidance and yell others in collaborate contribute only. Here, from this finding we can understand that adolescents of low resilient level use risky factors such as chewing chat, smoking as a coping mechanism which inversely affects their health status.

# Chapter Six

## 6. Summary, Conclusion and Recommendations

In this chapter major finding of the study was summarized, draws conclusions, and makes relevant recommendations for designing intervention strategies to improve adolescents' resilient capacity in line with the findings of the study.

## 6.1 Summary

The major objective of this study to assess the resilience level, risk behavior and protective factors of HIV positive adolescents who are a member of Mekidim Ethiopia National Association at Arad sub city. In line with the general objectives of the study, the following research questions are concerned;

1 Is there a significant difference among HIV positive adolescent in Mekidim Ethiopia National Association in their resilient level?

2 What are the risk behaviors that HIV positive adolescents are involved in?

3 What are the protective factors employed by HIV positive adolescents of Mekidim Ethiopia National Association?

4 Is there a statistically significant sex difference among HIV positive adolescents in their level of resilience?

5 Is there a difference in their level of resilience among HIV positive adolescents who use different protective factors?

One hundred (50 females and males 50) HIV positive adolescents were recruited and completed a battery of self-report questionnaire provided for participants. Based on pilot study item analysis was carried out and the instruments were improved.

Following data collection the results of the study were coded and interpreted using descriptive statistical methods. To investigate the resilience level of HIV positive adolescent in Mekidim Ethiopia National Association descriptive statistical methods mean and standard deviation was employed. In order to examine the risk behavior that HIV positive adolescents are involved in and to explore the protective factors employed by HIV positive adolescents of Mekidim Ethiopia National Association descriptive statistics percent were utilized.

In addition, to examine whether male and female HIV positive adolescents differ in their level of resilience and whether HIV positive adolescents differ in their level of resilience across ages Independent T test were employed. Furthermore, to explore the difference in the level of resilience among HIV positive adolescents who use different protective factors descriptive statistics percent were employed.

Based on the result of the study the following findings were drawn:

- The resilience level of HIV positive adolescents who are a member of the Mekdim Ethiopia National Association in Arada sub city is considered to be low. This finding tells us that HIV positive adolescents are low in their level of resilience.
- In general HIV positive adolescents who are a member of Mekdim Ethiopia National Association in Arada sub city are at risk of participating in activities which are a great impact on their health status. For instance, compared to other risky behaviors participants of the study more involved in, alcoholic behavior, use of smokeless and tobacco, sexual intercourse without any form of birth control and condom are the major factors.
- The protective factors that help HIV positive adolescents developa high resilient level are spirituality/ religion, living with their parents and relatives and also high in their educational status.

- There is no statistically significant difference between male and female HIV positive adolescents in their level of resilience observed. This implies that adolescents' level of resilience does not vary on account their sex differences.
- Adolescents of high levels of resilience are more involved in praying followed by talking to others as coping mechanism to overcome emotional disturbances they face in their daily routine life. The same trend was observed in the case of mid –level resilient adolescents except adolescents of mid –level resilient status use chewing chat and smoking as a coping mechanism. Similar with high and mid – level resilient adolescent's low level resilient adolescents also use praying and talking to others as a coping mechanism. But what makes this group different from high and mid-level resilient adolescents is that these low level resilient adolescents use potentially high risky behaviors such as chewing chat, smoking, and marijuana in high proportion as a coping mechanism.

## 6.2 Conclusions

Based on the result of the study the following conclusions were drawn

- The resilience level of HIV positive adolescents who are a member of the Mekidim Ethiopia National Association in Arada sub city is considered to be low. This finding tells us that the resilient capacity of adolescents living with HIV is low.
- In general HIV positive adolescents who are a member of the Mekidim Ethiopia National Association in Yeka sub city are at risk of participating in activities which are a great impact on their health status. For instance, compared to other risky behaviors participants of the study more involved in, alcoholic behavior, use of smokeless and tobacco, sexual intercourse without any form of birth control and use of Chat are the major factors.
- Among several protective factors religiosity, living with relatives and adolescent who have excellent educational status helps for HIV positive adolescents who are a member of the Mekidim Ethiopia National Association at Yeka sub city as a protective factors to develop a high resilience level.
- From this we can infer that compared to adolescents, those who are living with their biological parents and within shelters and foster care, adolescents, those who are living with their relatives and others were more prone to use unhealthy activities such as chewing chat, use of marijuana, smoking and the like activities as a means of coping to overcome their emotional problem.
- Similar with high and mid-level resilient adolescents, adolescents of low level resilient use praying and talking to others. But what makes this group different from high and mid-level resilient adolescents is that these low level resilient adolescents use potentially

high risky behaviors such as chewing chat, smoking, and marijuana in high proportion as a coping mechanism.

## 6.3 Recommendations

As it can be stated that HIV positive adolescents who are a member of Mekdim Ethiopia National Association at Arada sub city are at risk .Hence a variety of suggestions have to be offered in order to increase these adolescents level of resilience. For this reason it would be important to recommend some suggestion for parents of adolescents, Mekdim Ethiopia National Association at Arada sub city organization, and other concerned bodies so as to increase these adolescents resilient status. Hence, in line with the result found the investigator would like to recommend some suggestion

1. Mekdim Ethiopia National Association as Arada sub city organization should give training for parents and guardians of these adolescents on how to empathetically treat and provide important things for these adolescents and also provide parenting skill training thereby increasing these adolescent levels of resilience.
2. Parents and guardians of these adolescents should give special attention for these adolescents by giving love, support and understanding the adolescent's behavior in related to the HIV infection in all disease progress stages.
3. It is imperative to design parent or guardians and community based intervention program to avoid stigma, discrimination and create conducive environment for HIV positive adolescents to discuss freely on their specific issues to improve these adolescents' resilient statuses and to increase positive coping mechanism in these adolescents.
4. Mekdim Ethiopia National Association as Arada sub city organization should facilitate cooperative involvement and communication among different parents' work on the

adolescent and youth issues and policy makers to give special attention to make for these adolescents productive citizens.

5. Among the protective factors that contributes to adolescents have a higher resilient status are praying and talking to others as the major protective factor, thus adolescents of middle and low resilient status should be encouraged to increase praying and talking to others about their problems as a major protective factor.
6. Since research findings on the resilience level, risk behavior and protective factors of HIV positive adolescents in our context is scanty, further studies need be to conduct in the area of concern.

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# Appendices

**Addis Ababa University**

**College of Education and Behavioral Studies**

**School of Psychology**

The objective of the questionnaire is to explore the resilience, risk behavior and protective factors of adolescent. Any information you provide is highly confidential and used only for the purpose of this study. Thus, please try to answer the following questions in a way that you think is right for you.

**General Instructions**

This questionnaire has two parts. The first part is demographic information where you are required to provide general information about yourself. And the next section is the main part where question are directly related to the issue of resilience level, risk behavior and protective factors.

**Part One - Demographic Information**

1. Gender 1. Male _____ 2. Female _____
2. Age _____
3. What is the highest grade you achieved? _____
4. With whom are you living now?
    1. with a parent(s).
    2. with a grandparent(s) or other family member(s)
    3. with a foster family
    4. in shelter care
    5. Independently
    6. Other (Specify) _____
5. Are you currently attending school?
    1. Yes_____ 2. No_____

6. If Yes to the above question, what is your performance at school?

1. Excellent
2. above average
3. Average
4. below Average

**Part Two: Protective Factor identification Questions**

1. What mechanism do you use to cope up with the emotionally stressful situation? From listed

1. Play 2. Talk to somebody 3. Drink alcohol

4. Chew chat 5. Withdrawal from activities

6. Thought avoidance 7. Yell others 8. Smoking cigarette

9. Other, please specify _____

2. Have you ever participated in any school/community/ association /clubs? ----------

3. Are you currently engaged in gainful work activities 1. Yes_____2. No_____

4. If your answer to question No 16 is "Yes", please indicate the type of work that you are engaged.

5. Please mark (√) to the listed activities that you actively participate in

1. Anti AIDS club 2. Sport club 3. Youth club

4. Mini media club 5. Religious association

6. Student Associations 7. Drama/Music club

8. Other, please specify _____

| Item | No one | My Siblings | My Relatives | My Neighbors | Friends | My school Teachers | Religious leaders | My parents/ guardians | Other, please write |
|---|---|---|---|---|---|---|---|---|---|
| 6. Who do you want to talk to be with when you are feeling 'down'? | | | | | | | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 7. Who is the first person you would tell if you were worried about something? | | | | | | | | | |
| 8. Who do you think cares for your wellbeing? | | | | | | | | | |
| 9. Who tries to fulfill your needs? | | | | | | | | | |
| 10. Who often guides you in your day to day activities? | | | | | | | | | |
| 11. Who makes most decisions concerning your life? | | | | | | | | | |
| 12. Who is your role model for life? | | | | | | | | | |

**Part III: Measurement Scale for Adolescent Level of Resilience English Version**

Please read the following statements. To the right of each you will find five numbers, ranging from "0" (Not true at all) on the left to "4" (Applies somewhat) on the right. Put ticks (√) below the number which best indicate your feelings about that statement.

0- Not true at all

1- Rarely true

2- Sometimes true

3- True, nearly all the time

4- Applies somewhat

| Item | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| Able to adapt to change | | | | | |
| Close and secure relationship | | | | | |
| Sometimes fate/God can help | | | | | |
| Can deal with whatever comes | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Past success gives confidence for a new challenge | | | | | |
| See the humorous of side of things. | | | | | |
| Coping with stress, strengthens | | | | | |
| Tend to bounce back after illness and hardship | | | | | |
| Things happen for a reason | | | | | |
| Best effort, no matter what | | | | | |
| I can achieve my goals | | | | | |
| When things look hopeless, I do not give up | | | | | |
| Know where to turn for help. | | | | | |
| Under pressure focus and think clearly. | | | | | |
| Prefer to take the lead in problem solving. | | | | | |
| Not easily discouraged by failure. | | | | | |
| Think of self as a strong person | | | | | |
| Make unpopular or difficult decision | | | | | |
| Can handle unpleasant feelings | | | | | |
| Have to act on a hunch. | | | | | |
| Strong sense of purpose | | | | | |
| In control of my life | | | | | |
| I like challenges | | | | | |
| I work to attain my goal | | | | | |
| Pride in my achievement | | | | | |

**Part IV. Adolescent Risk Behavior Rating Scale**

**DIRECTIONS**: Read each one carefully and circle the number that corresponds to the frequency with which you participate in that activity: Never, Rarely, Sometimes, and Often.

There are no rights or wrong answers. ALL RESPONSES ARE COMPLETELY ANONYMOUS.

*Note*. 1 =*Never*, 2 = *Rarely*, 3 = *Sometimes*, 4 = *Often*

| Ser. No | Item | Never | Rarely | Sometimes | Often |
|---|---|---|---|---|---|
| 1 | I carry a gun or knife on school property. | | | | |
| 2 | I cheat on my school work/tests | | | | |
| 3 | I drink beer, wine, or liquor | | | | |
| 4 | I chew chat | | | | |
| 5 | I use tobacco products (cigarettes, cigars, chew, etc.). | | | | |
| 6 | I have sex without any form of birth control | | | | |
| 7 | I had sex without using condom | | | | |
| 8 | I drink alcohol | | | | |
| 9 | I skip school without telling my family. | | | | |
| 10 | I think about killing myself. | | | | |
| 11 | I tease and make fun of other students or adults. | | | | |
| 12 | I tell lies about other students or adults. | | | | |
| 13 | When I use alcohol, I have more than two drinks within an hour | | | | |

**አዲስ አበባ ዩኒቨርሲቲ**

**የስነ-ልቦና ትምህርት እና ባህርይ ጥናት ኮሌጅ**

**የስነ-ልቦና ትምህርት ቤት**

የዚህ መጠይቅ ዋና ዓላማ የወጣቶችን ችግርን የቋቋም ደረጃቸውን ለማወቅ የሚያስችል መረጃን መሰብሰብ ነው፡፡ የጥናቱ አስተማማኝነት እና ትክክለኛነት የሚወሰነው አንተ/ቺ በምትሰጠው /በምትሰጪው ምላሽ በመሆኑ እያንዳንዱን ጥያቄ በመመሪያው መሰረት እንድትሞሉ በትህትና እጠይቃለሁ፡፡

**ማሳሰቢያ፡-** - በመጠይቁ ላይ ስም መፃፍ አያስፈልግም

- የምትሰጡት ምላሽ በሚስጥር ተጠብቆ ለጥናቱ ውጤት ብቻ ይውላል፡፡

ለምትሰጡት ምላሽ ሁሉ ከወዲሁ አመሰግናለሁ፡፡

**ክፍል አንድ- አጠቃላይ መረጃዎች**

1. ጾታ 1/ወንድ----------2/ ሴት----------
2. እድሜ---------- ዓመት/ በሙሉ አመት ይጻፍ/
3. ከፍተኛው የትምህርት ደረጃህ/ሽ----------
4. አሁን ከማን ጋር ነው የምትኖረው/ሪው?

1/ ከወላጆቼ ጋር 2/ ከአያቶቼ ጋር

3/ ከስጋ ዘመድጋር 4/ ከአሳዳጊዎቼ ጋር

5/ በመኖሪያ ካምፕ ውስጥ 6/ ብቻዬን

7/በመጠለያ 8/ሌላ ካለ ይገለጽ----------

5. በአሁን ጊዜ ትማራለህ? 1.አዎ---------- 2. አልማርም---------
6. ለተራ ቁጥር 5 “አዎ” ከሆነ መልሱ የትምህርት ደረጃህ ምን ይመስላል?

1/ እጅግ በጣም ጥሩ ነበር 2/ ከደረጃ ከፍያለ ነበር

3/ መካከለኛ ነበር 4/ ዝቅተኛ ነበር

**ክፍል ሁለት - ፕሮቴክቲቭ ፋክተር መለያ መጠይቅ**

1. ስሜትህን/ሽን የሚያስጨንቅ ሁኔታ ሲገጥምህ/ሽ ከዚህ ጭንቀት ለመውጣት ከዚህ በታች ከተዘረዘሩት ውስጥ የቱን ዓይነት የመቋቋሚያ ስልት ትጠቀማለህ/ትጠቀሚያለሽ

    1/ መጸለይ

    2/ ለሰዎች መናገር

    3/አልኮል መጠጥ መጠጣት

    4/ጫት እቅማለሁ

    5/ ስራን በማስወገድ ምንም ነገር ከመስራት እቆጠባለሁ

    6/ በሌሎች ላይ እጮሃለሁ

    7/መድሃኒት መጠቀም

    8/ሌሎችን መጉዳት

    9/ሲጋራ ማጨስ

    10/ እባክዎ ሊሎች ካሉ ይዘርዝሩ----------

2. በማኛውም የትምህርት ቤት ክበብ ውስጥ ተሳትፈህ/ሽ ታውቃለህ/ታውቂያለሽ

    1. አዎ----------  2. አላውቅም----------

3. የተሳተፍክበት/ሽበት የክበብ ዓይነት ፊትለፊት/ √/ ይህንን ምልክት አድረግ/ጊ

    1.ፀረ ኤድስ ክበብ  2. የስፖርት ክበብ

    3.የወጣቶች ክበብ  4. የሚኒሚዲያ ክበብ

    5.የሀይማኖት ማህበራት  6. የተማሪዎች ማህበራት

    7. የድራማ ወይንም የሙዚቃ ክብበ  8. ሌሎች ካሉ ይጠቀሱ----------

4. አሁን አንተ/አንቺ ጥቅም በሚያስገኝ ስራ ላይ ተሰማርተሃል/ሻል

1.አዎ 2.አይደለም

5. መልስህ/ሽ አዎ ከሆነ እባክህ/ሽ የስራውን ዓይነት ግለፅ----------

| ዝርዝር መጠይቅ | ማንም | ወንድምእና እህቶቼን | ዘመዶቼን | ጎረቤቶቼን | ጓደኞቼን | መምህሮቼን | የሀይማኖት አባቶችን | የመንግስት ሰራተኞችን | ሌላከለ ይጻፍ |
|---|---|---|---|---|---|---|---|---|---|
| 6.ሀዘን ሲኖረብህ/ሽ ማናግረ ወይም አብሮ መሆን የምትፈልጊው ሰው ማነው? | | | | | | | | | |
| 7.የሆነ ጉዳይ "ቢያስጨንቅህ/ሽ መጀመሪያ የምታናግረው/ሪው ሰው ማነው? | | | | | | | | | |
| 8.ባንተ/ቺ አመለካከት ላንተ/ቺ የሚጨነቅ ሰው ማነው? | | | | | | | | | |
| 9.ከማንም የበለጠ መሰረታዊ ፍላጎትህን/ሽን ለማሟላት የሚጥርልህ/ሽ | | | | | | | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ማነው? | | | | | | | | | |
| 10.የዕለት ተዕለት ያለውን ስራህን/ሽን በአብዛኛው የሚቆጣጠር ማነው? | | | | | | | | | |
| 11.ህይወትህን/ሽን በተመለከተ ብዙ ጊዜ ውሳኔ የሚያደርገው ማን ነው? | | | | | | | | | |
| 12.ምሳሌ እየሆነህ/ሽ ያለ ባብዛኛውየምትከ ተለው/ዊ ሰው ማነው? | | | | | | | | | |

**ክፍል ሦስት- ችግሮችን የመቋቋም አቅም ደረጃ መመዘኛ መጠይቅ**

**ጥያቄዎችን በጥሞና ካነበባችሁ በኋላ ለቀረቡት ጥያቄዎች የእናንተን የስምምነት ደረጃ ይበልጥ የሚገልፀውን አማራጭ ላይ ምልክት በማድረግ ይግለፁ፡፡**

0. ፈጽሞ እውነት አይደለም
1. በጥቂቱ እውነት ነው
2. አንዳንዴ እውነት ነው
3. ባብዛኛው እውነት ነው
4. ሁልጊዜ እውነት ነው

| መጠይቅ | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| ህይወቴ ውስጥ ከሚመጡ ለውጦች ጋር እራሴን ማስተካከል እችላለሁ | | | | | |
| ከሰዎች ጋር ቅርብና አስተማማኝ ግንኙነት አለኝ፡፡ | | | | | |
| በፈጣሪ ማመን ወይም በእድል ማመን አንዳንዴ ይረዳል፡፡ | | | | | |
| ምንም ነገር በህይወቴ ቢመጣ መቋቋም እችላለሁ፡፡ | | | | | |
| ባለፉት ጊዜያት የተሳኩልኝ ነገሮች ወደፊት ለሚገጥሙኝ ፈተናዎች በራሴ ተማምኜ እንድዘጋጅ ይረዱኛል፡፡ | | | | | |
| ሁሉ ነገር የሚሆነው ለበጎ ነው ብዬ አምናለሁ፡፡ | | | | | |
| ችግሬን ብቋቋም ለወደፊት ያጠነክረኛል፡፡ | | | | | |
| ከበሽታ ወይም በህይወቴ ከሚደረስ መከራ ብዙ ጊዜ ቶሎ አገግማለሁ፡፡ | | | | | |
| ነገሮች የሚከሰቱት ለምክንያት ነው፡፡ | | | | | |
| ምንም ቢሆን ምንም የተቻለኝን ጥረት ለማድረግ እሞክራለሁ፡፡ | | | | | |
| አላማዬን ከግብ ለማድረስ እሞክራለሁ፡፡ | | | | | |
| ሁኔታዎች ተስፋ እንድቆርጥ ቢገፋፉኝም ተስፋ አልቆርጥም፡፡ | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| ለችግር ጊዜ ለእርዳታ ወደ ማን እንደሚሄድ አውቃለሁ፡፡ | | | | | |
| በውጥረት ጊዜ ነገሮችን በትኩረት እና በትክክል ማሰብ እችላለሁ፡፡ | | | | | |
| ችግሮችን ለመቅረፍ በቀዳሚነት እንቀሳቀሳለሁ፡፡ | | | | | |
| በህይወቴ በሚደርሱብኝ አንዳንድ ውድቀቶች ቶሎ ሞራሌ አይነካም፡፡ | | | | | |
| እራሴን ጠንካራ አድርጌ እቆጥራለሁ፡፡ | | | | | |
| ብዙ ጊዜ ያልተለመዱ እና ለመወሰን የሚከብዱ ውሳኔዎችን እወስናለሁ፡፡ | | | | | |
| የሚረብሹኝን ስሜቶችን እቋቋማለሁ፡፡ | | | | | |
| የሚታዩኝ መልካም አጋጣሚዎችን ወዲያው እጠቀማለሁ፡፡ | | | | | |
| የኔ መኖር አስተዋጽኦ አለው ብዬ አምናለሁ፡፡ | | | | | |
| የኔን ህይወት እምመራው እኔው ነኝ ብዬ አምናለሁ፡፡ | | | | | |
| የህይወት ፈተናዎችን እወዳቸዋለሁ፡፡ | | | | | |
| የህይወቴን አላማ ለማሟላት እጥራለሁ፡፡ | | | | | |
| በህይወቴ ውስጥ በተላኩልኝ ነገሮች እኮራለሁ፡፡ | | | | | |

**ክፍለ አራት፡- በጉርምስና እድሜ ላሉ ለአዳጋ ተጋላጭነት መለኪያ**

| ተራ ቁጥር | መጠይቅ | አልፎአ ልፎ | አንዳንድ ጊዜ | ቶሎቶሎ | በፍጹም |
|---|---|---|---|---|---|
| 1 | የጦር መሳሪያ ወይንም ስለት ነገር የትምህርት ቤቱን ንብረት ለመጠበቅ እይዛለሁ፡፡ | | | | |
| 2 | በትምህርት ስራ ወይንም በፈተና ላይ አጭበረብራለሁ፡፡ | | | | |
| 3 | ቢራ ወይን ወይንም ሌላ መጠጥ እጠጣለሁ፡፡ | | | | |
| 4 | ጫት እቅማለሁ፡፡ | | | | |
| 5 | ሲጋራ ወይንም ሌላ የሚጨስ የሚቃም ነገር እጠቀማለሁ፡፡ | | | | |
| 6 | ምንም አይነት የወሊድ መከላከያ ሳልጠቀም ግብረ ስጋ ግንኙነት እፈጽማሁ፡፡ | | | | |
| 7 | ኮንደም ሳልጠቀም ግብረስጋ ግንኙነት እፈጽማሁ፡፡ | | | | |
| 8 | አልኮል እጠጣለሁ፡፡ | | | | |
| 9 | ለቤተሰቤ ሳልነግር ከትምህርት ገበታዬ ላይ እቀራለሁ፡፡ | | | | |
| 10 | ራስንሴ ለማጥፋት አስባለሁ፡፡ | | | | |
| 11 | በሌሎች ሰዎች ላይ እቀልዳለሁ ወይንም አሾፋለሁ፡፡ | | | | |
| 12 | ለጓደኞቼ ወይንም ለአዋቂዎች ውሸት እነግራለሁ፡፡ | | | | |
| 13 | አልኮል ስጠጣ በአንድ ሰዓት ከሁለት ብርጭቆ በላይ እጠጣለሁ፡፡ | | | | |

# Declaration

I, Liyu Wogayehu, declare that this work is my original work, has not been submitted for any degree in this university and that all sources of materials used for the study have been duly acknowledged.

Name: Liyu Wogayehu

Signature: _____

Place: Addis Ababa University

Date of Submission: Feb, 2015